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Mental State of Inquiry:
Tragedy, Policy and Accountability in the Case of the Ritchie Inquiry

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Preface

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Mental State of Inquiry: Tragedy, Policy and Accountability in the Case of the Ritchie Inquiry

Abstract: this paper examines the relationship between politics of accountability and the politics of independent inquiries in the UK in the case of the Ritchie inquiry. The study suggests that related events around the time of the incident and the active role of professional campaigners and eloquent victims appear to have contributed importantly to the pressure on the government to appoint an inquiry. Yet an analysis of the inquiry report against to the limitations of its emphasis on operational aspects. The combination of intense public pressure coupled with investigative emphasis on operational matters (rather than policy) can account for the advent of mandatory inquiries into this type of incidents between 1994 and 2001.

I wish to thank Alan Simpson for his helpful comments and suggestions on an earlier draft of this paper. Any faults that remain are of course my own.
Concept Introduction: Independent Inquiries and Accountability

How do some social problems become subject matter for accountability processes? What are the relationships between the way problems are perceived, and the way they are accounted for by formal bodies? And does the way accountability is practiced affect public understanding of social problems? This paper attempts to address these questions in a case study of a UK public inquiry – the Ritchie inquiry into the killing of Jonathan Zito by Christopher Clunis, a released mental health patient. More specifically, the paper attempts to trace the events which appear to have led to the appointment of the inquiry, the political reactions to the inquiry process and report, and suggest some evaluations of the process and outcome, with an emphasis on issues of accountability and policy change.

Inquiries in the UK

The term ‘inquiry’ in the context of this paper refers to ‘independent inquiries’ – which are formally external to the executive. Generally speaking, when an independent inquiry conducts its proceedings in public and publishes its report, it is typically referred to as a ‘public inquiry’. Yet, this term is often used to denote different types of institutions and functions (PASC 2005: 7). Important distinctions can be made, for example, between planning, advising and investigating inquiries. Based on Sulitzeanu-Kenan (2006a: 624) the following criteria will be used to define an inquiry:

1. An ad hoc institution: i.e., established for a particular task; and once its primary task is concluded, the tribunal is dissolved;
2. formally external to the executive;
3. established by the government or a minister;
4. for the main task of investigating;
5. past event(s).

For the purpose of clarity, it is worthwhile sketching the various types of inquiries that may be instigated by the executive. Relying on Sulitzeanu-Kenan (2007) the various types of governmental investigative response are given in Table 1. These types all satisfy four out of the five criteria – ad hoc inquiries, established by a minister or the government,
for the purpose of investigation of past events. Yet the requirement that an inquiry is external to the executive, termed here as ‘independent’, is relaxed, and the requirement to conduct the inquiry in public was added, allowing for two dichotomous conditions. Within independent inquiries a particular aspect has also been included – the choice of a judge to serve as inquiry chairperson – judicial inquiry – or a non-judicial chairperson. The three dichotomous conditions comprise a three by two matrix, with six cells.

Table 1: Governmental investigative response types

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<tr>
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<th>Internal Non-judicial</th>
<th>Independent Non-judicial</th>
<th>Independent Judicial</th>
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<tr>
<td><strong>Private</strong></td>
<td>An inquiry that does not satisfy the independence condition, and the publicity condition, eg inquiry into the Parkhurst prison escape (1995)</td>
<td>An inquiry that does not satisfy the publicity condition, eg inquiry into Ashworth mental hospital: paedophilia, pornography and financial irregularity (1997)</td>
<td>A judicial inquiry that does not satisfy the publicity condition, eg inquiry into the collapse of BCCI (1991)</td>
</tr>
<tr>
<td><strong>Public</strong></td>
<td>An inquiry that does not satisfy the independence condition, eg inquiry into the rail crash on the Kent–Sussex border (1994)</td>
<td>An inquiry that satisfies all the criteria, eg inquiry into the Southall rail crash (1997)</td>
<td>A judicial inquiry that satisfies all the criteria, eg inquiry into the Cleveland sex and abuse row (1987)</td>
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Source: Sulitzeanu-Kenan (2007)

Accountability and Inquiries

Accountability functions to expose and sanction illegitimate exercise of power and decisions that are judged to be either practically or normatively flawed. In a political context ensuring accountability requires establishing institutions that provide information to accountability holders and enable them to impose sanctions (Grant and Keohane 2005: 30).

It is accepted that public inquiries have come to play a pivotal part of public life in Britain, and a major instrument for holding officeholders and organizations to account. Inquiries provide both information and clarify responsibility in serving the functioning
of ministerial responsibility to Parliament (PASC 2005). In so doing, inquiries clearly provide both information for policy learning and allocating responsibility, and also serve in redefining norms of legitimacy for weighing and evaluating the information they provide.

It appears that despite their intended a-political and impartial characteristics, inquiries remain politically contested all throughout their life-cycle. Indeed it has been claimed that such investigative bodies are “a continuation of politics by other means” (Gove 2003). First and foremost, the very decision whether or not to appoint an inquiry into a given affair is typically a disputed matter. A comprehensive analysis of these decisions suggests that events and affairs that are inquired into are quite rare (6.6%), given the demand for inquiries. More salient issues are more likely to be appointed an inquiry, suggesting that public pressure accounts for the propensity of ministers to appoint inquiries. As blame for the affair is attributed to agents closer to the appointing minister, the less likely is she to appoint an inquiry into that affair (Sulitzeanu-Kenan 2006b). Moreover, the scope of an inquiry is typically the result of the government’s attempt to narrow the terms of reference (temporally and substantively), while its critiques (opposition, media) call to widen them (Woodhouse 1995, McLean and Johnes 2000: 221, Jenkins 2002). As such, the politics of inquiries conforms with the general characteristics of the ‘politics of accountability’, which suggests that elected and appointed officials tend to disfavour policies aimed at increasing accountability, particularly when these call upon them to account (Wildavsky 1972, Weiss 1973, Palumbo 1987, Schwartz 1998, Schwartz and Sulitzeanu-Kenan 2002, Maor 2004).

The general public and critical elite observers (opposition members, journalists) tend to demand an inquiry almost as a reflex response to crisis. Yet although the standard normative argument about the role of inquiries, as credible providers of an authoritative account (Salmon 1966, Clarke 2000: 8, McLean 2001: 592), the credibility allotted to their reports is not guaranteed. Sulitzeanu-Kenan (2006a) has found that an inquiry’s credibility is dependent upon the content of its report. Thus, rather than the institution (inquiry) qualifying the account (report), it is the agreeableness of the account that qualifies the institution. This dynamic suggests that demand for an inquiry is not (merely) driven by a quest to discover an (unknown) truth, but rather to secure an authoritative confirmation for a preconceived judgement of the situation.

To conclude, although inquiries can potentially serve to promote accountability, as noted above, their conception, operation, and legacy are subject to these characteristics of the politics of inquiries.
Case Introduction and Historical Context

Inquiries that qualify for the above criteria come into existence in a variety of circumstances, and they range from fairly routine investigations of specific types of misfortunes to unique and extreme disasters and fiascoes. This case is concerned with the Ritchie Inquiry, appointed by the Minister of Health, Virginia Bottomley, on June 27, 1993 into the killing of Jonathan Zito by Christopher Clunis, a released mental health patient.

A more specific definition of inquiries in the British National Health Service (NHS) is quite similar to the general one provided earlier:

A retrospective examination of events or circumstances surrounding a service failure or problem, specially established to find out what happened, understand why, and learn from the experiences of those involved. It can be public or in private; may be independent of those who established it; may have some judicial powers to summon witnesses and gather evidence; and usually reports formally (Walsher and Higgins 2002: 895).

Following the typology above, the Ritchie Inquiry can be categorized as type 3 inquiry – an independent and private inquiry – although its report was made public.

Policy context: development of ‘care in the community’ policy

Theoretical ideas in mental health care and pharmaceutical advances had joined forces to set the stage for the advent of ‘care in the community’ – the most significant policy change in mental healthcare in the history of the NHS. Normalization theories in the 1960s reinforced the right of the mentally ill to be valued in society and to participate in the mainstream of life; and the introduction of neuroleptic drugs greatly facilitated to care for people with severe psychiatric problems outside a hospital setting, thanks to their effectiveness in reducing psychotic symptoms. These developments paralleled a long and gradual deterioration in the state of mental hospitals in the UK. Buildings and infrastructure were aging, and recruitment of staff difficult. Yet despite this situation and even after a number of well-publicized scandals relating to the treatment of patients in long-stay hospitals raised public interest and concern, progress in this public service was slow (Hallam 2002: 27).

In line with Kingdon’s (1995) notion of ‘window of opportunity’ this situation has changed when the emphasis on community care came to be coupled with the Conservative
Government’s ‘value-for-money’ imperative in the 1980s. The assumption was that hospitals providing long-term care were more expensive than community services of comparable quality. Moreover many hospitals were situated on prime building land, which could be sold and yield short term income. (Hallam 2002: 27-8). Community care appeared to answer the concerns associated with big hospital institutions, the civil rights of the mentally ill, and the push to cut costs of public services.

However, by the mid 1980s a number of killings by mental patients have raised concern about the policy and its implementation. The murder of social worker Isabel Schwarz by a former client led the government to set up the Griffiths inquiry into community care. The Griffiths report recommended targeted care packages and the appointment of case managers who would assess the needs of mentally ill people, co-ordinate among the various agencies and maintain close interaction with families. The consequent Community care Act, 1990, however, did not address specific proposals concerning mental health (Simpson et al. 2003: 490).

In 1990 Stephen Dorrell, the Junior Health Minister announced that the Government intends to shift from hospital-based psychiatric care to community-based treatment. The early 1990s saw increasing public concern over the rundown and closure of long-stay psychiatric hospitals, resulted sometimes in former patients becoming homeless, and what generally was judged as inadequate community care. A number of tragedies which preceded the killing by Christopher Clunis had led the Department of Health in 1991 to set up an inquiry into suicides and homicides by people with mental illness, headed by Dr William Boyd. April 1993 (three months after the Clunis incident) was scheduled for implementing the final phase of the 1990 NHS and Community Care Act – restructuring of social services departments and changed roles for social work staff. The general atmosphere among service professionals was of dislocation and suspicion as the core of the Government’s policy was understood to be an attempt to curtail excessive spending on residential care (Hallam 2002: 28).

The Story - The killing of Johnathan Zito by Christopher Clunis

Jonathan Zito, 27, was stabbed to death on an Underground platform in London by Christopher Clunis, 29, on Thursday 17 December 1992. Zito had gone with a friend to drive family visitors from Gatwick to his Crouch End flat. Since there was not enough room in the car, he and his elder brother Christopher decided to return by public transport. They were standing on the platform at Finsbury Park when Clunis approached them and stabbed Jonathan. The killer then ‘quite calmly’ boarded a train. Jonathan
collapsed into his brother’s arms and was taken to Whittington hospital where he died from a single stab wound to the face which pierced his eye socket and entered the brain. Police officers, which arrived at the scene within minutes of the stabbing, apprehended Clunis, who was positively identified by witnesses. In his left hand trouser pocket an officer found a bloodstained wooden handled folding knife (Mail of Sunday 20.12.1992, Daily Mail 29.6.1993, Ritchie et al. 1994: 99-101).

The earliest report about the murder in the national press was two days later (19.12.1992) in a short article (53 words) in the Times, which reported that Clunis was charged. This report only mentioned that Clunis was unemployed at the time. The next day some additional details about the incident were reported by the Mail on Sunday (20.12.1992). Apart from the tragic death of Zito, the single most import fact that was later to frame this event in public memory and policy was not included in these reports – namely that Christopher Clunis was a mental patient suffering from schizophrenia.

The incident at London Zoo

Following these two brief press reports there was no mention of the event in the national press for a full six months. However, another incident involving a mental health patient occurred only two weeks after Zito’s killing. On New Year’s Eve 1992 a young men by the name of Ben Silcock climbed into the lions’ enclosure at London Zoo. He was seen scaling the perimeter fence from Regent’s Park, near the children’s zoo at lunchtime. He ran towards the lion enclosure and crouched in the bushes. Witnesses saw him throwing chickens into the den before scaling the 20 feet mesh and jumping into the enclosure. He was near the middle of the compound, walking to the moat, when one of the lions leapt at him. Zoo keepers set off fire extinguishers and fired shots into the air to distract the three 25-stone Asiatic lions, among the world’s rarest, which were shut inside before doctors entered the enclosure to help Mr Silcock. He was taken in a serious condition by air ambulance to the Royal London Hospital, Whitechapel, where he underwent emergency surgery (Times 1.1.1993).

On that New Years Eve, the British public was transfixed by video footage of the incident at London Zoo, broadcast on their television screens. It was later reported that Ben Silcock, who survived this ordeal was an untreated mentally ill person, suffering from schizophrenia. Unlike the initial media response to the killing of Zito by Clunis, the Silcock incident received massive media attention. On 2 January 1993 the Daily Mail featured an article under the headline ‘Can no one help tragic young men like Ben?’ The writer, Marjorie Wallace, was a friend of the Silcock family who, as a journalist, had
worked with Ben’s father. It so happened that Marjorie Wallace was also Chief Executive of the voluntary organization ‘Schizophrenia A National Emergency’ (SANE) and an experienced mental health campaigner. Virginia Bottomley had contacted Marjorie Wallace after reading her article and discussed the issue with her. Two days later, the *Daily Mail* ran the headline ‘Ben’s tragedy brings hope: Minister acts after the Mail’s disturbing report on lion man’. The article reported that the Health Secretary was ‘planning a shake-up of mental health laws’ following the London Zoo incident. While press coverage of the Silcock case was extensive, it is clear that the *Mail* was running a campaign, following Ms. Wallace’s article, and its apparent policy implications (Hallam 2002: 29). It is possible that this campaign by the *Mail* had an inter-media effect on other news sources (Reese and Danielian 1991), resulting in the extreme media attention to this incident. Ben Silcock became “an instant symbol of the apparent failure of community care policy” (Rumgay and Munro 2001: 358).

Two omissions in the unfolding of the Silcock affair are relevant to this study. First, it should be noted that this affair did not lead to calls for the appointment of a public inquiry. The second, is the lack of any reference to the Clunis case, which occurred only two weeks earlier, throughout this extensive media coverage. As suggested by Hallam (2002: 29) this latter omission indicates that Clunis’ mental illness was not publicly known at the time.

### The Government’s response to the Silcock incident

In January, Mrs Bottomley ordered a review of the law governing community care of patients discharged from mental hospital following the case of Ben Silcock. She initially said that she favoured proposals put forward by the Royal College of Psychiatrists for community supervision orders requiring patients to take their drugs and attend regular check-ups. This plan has been later criticised by patients’ groups, and in June 1993 Mrs Bottomley appeared to draw back on the issue, when she told the Commons health committee that no proposal yet put forward had offered an answer to the problem (the *Guardian* and *Times* 3.7.1993).

### The end of the Clunis trial – the case becomes public

On June 28 1993 the trial of Christopher Clunis came to a close at the Old Bailey in London. The next day a series of long and detailed articles about the case appeared in the British press and, for the first time since the incident, reported that Clunis was a “knife-crazy paranoid schizophrenic, with a long history of violence”, who “was released
into the community with no supervised treatment three months before” the deadly attack took place (The Times 29.6.1993). Due to his mental state Clunis pleaded guilty to manslaughter (rather than murder) on grounds of diminished responsibility, and was sentenced to indefinite internment at a secure hospital (The Independent 29.6.1993). New information was also provided on the victim. In these articles Zito was described as “an Italian-American musician and composer”, who had been in London just six weeks with “the English wife he met while she was visiting her father, an artist, in Tuscany” (Daily Mail 29.6.1993).

The articles in the Times and the Guardian both begin with the demand of Zito’s widow for the appointment of a public inquiry into the Government’s community care policy and the circumstances that led to the murder. Clunis’ lawyers, on their part, were reported to have written the Health minister Virginia Bottomley complaining about the “deplorable lack of care for this young man in the community” (Times and Guardian 29.6.1993).

The medical history of Christopher Clunis

The most important fact that singles out the killing of Jonathan Zito from other homicides is his assailant’s mental health condition. Indeed, until this fact became publicly know, the case did not receive any public, media or policy attention. It is Christopher Clunis’ medical history and condition at the time of the attack that make this tragic private incident into a matter of public policy concern. Moreover, unlike most homicides by mental patients, this incident involved the death of a complete stranger (rather than a family member or a social or health practitioner), and therefore led to great public anxiety (Simpson et al. 2003: 491).

John Bevan, for the prosecution, had told the court that Clunis’s psychiatric problems dated back to August 1986 when London-born Clunis was admitted to a mental hospital in Kingston, Jamaica, where his late mother had been living. He was diagnosed as a paranoid schizophrenic, but responded to treatment and was discharged. He returned to the UK in June 1987 and, six months later, was admitted to Chase Farm hospital where he was diagnosed as a transient psychotic. In spring, 1988, he was remanded to Brixton Prison, convicted of causing criminal damage. Clunis’ defending lawyer, Mr Fulford, has argued that from then onwards the authorities were put under the clearest notice that with every relapse there was an increasing deterioration in his client’s behaviour. Mr Bevan added that Clunis harboured “a fascination” for knives. In June 1989, he was taken under a place of safety order to St Mary’s Hospital, Paddington. On
his release he was put into bed-and-breakfast accommodation, where there was a fire and he attempted to stab a policeman after barricading himself in his room. In July 1990 he was found in Brixton sucking a dummy and making strange noises. He returned to hospital but ‘difficulties’ were reported in August 1991 and he was discharged, despite a failure to respond to drugs.

In May 1992, seven months before his fatal attack on Zito, he was held for allegedly stabbing a Southwark hostel room-mate in the neck. He was remanded to Belmarsh Prison and in August transferred to the York Clinic at Guy’s Hospital. The case against Clunis collapsed when the alleged victim refused to give evidence. By September 26, less than three months before the Zito incident, he was considered to be in an appropriate mental state for discharge and moved back to North London. Based on Clunis’ lawyer, arrangements were made by Guy’s Hospital for outpatient psychiatric appointments at Friern Barnet Mental Hospital in north London. Social services were told he should not need any social work input at the present time. Clunis missed an appointment with a psychiatrist on October 9, and notes outlining his violent past did not arrive at Friern Barnet from Guy’s Hospital until November. Mr John Bevan, prosecuting lawyer, was reported to have said: “It is extremely unfortunate that after the discharge from Guy’s, no substantial psychiatric or social work follow-up was made” (Daily Mail, Independent, and Guardian 29.6.1993). Dr Nigel Eastman, a consultant forensic psychiatrist, said Clunis responded well to medication in a controlled environment, but as soon as he was released his condition would deteriorate again, since he did not understand anything was wrong and therefore stopped taking his medication. “If he had got a place at Rampton Hospital it is very much less likely that this offence would have occurred. The reason he did not go there is that no bed was available at the time.” (The Times, 29.6.1993). Mr Bevan said: “The failure of care-in-the-community led to yet another deterioration in his health on his release, as a result of which Jonathan Zito was the random victim.” (Independent, 29.6.1993). This later statement represents the connection made by various observes between the particular events leading to the attack on Zito, and the alleged failure of the government’s policy. The next section deals with this aspect of the case more specifically.

Criticism of the Government’s policy

Solicitors for both sides called on the agencies responsible for Clunis’s care to explain why such an obvious threat to public safety was allowed to roam apparently unattended. A more direct accusation of the government, and a plea for accountability for the event was leveled by the widow, Mrs. Jayne Zito:
Somebody is responsible for murdering my Jon. … I want there to be a public inquiry into why Jonathan Zito has died… Somebody has to tell me why Christopher Clunis was on the platform that day and murdered my husband. We heard this morning that this need not have happened. If someone had taken care of Mr Clunis, my husband Jon would have been here with me today. The man who stabbed Jon was so disturbed and vulnerable and distressed and frightened and scared, that he murdered my husband without even needing to see his face (Daily Mail, June 29, 1993).

An important part in Mrs Zito’s message was the lack of blame towards Clunis, while holding the health authorities, and in fact the government responsible for allowing him to be in that situation. She said she knew only too well the trauma suffered by patients who were unwillingly sent out into the community:

I worked for years with vulnerable people like Mr Clunis, who are very frightened, who need supervision and help. They’re so scared, but they have nowhere to go and nobody to care for them. They cannot take responsibility for what they do (Independent, June 29, 1993).

Blaming her husband’s death on the Department of Health’s drive towards treating mentally ill people as out-patients she added that the government should:

understand that the changes they are making lead to destruction and fear and extreme loss, not only for me and my family, but for Christopher Clunis and his family and for all the people that are vulnerable. … Government policy for community care has failed in the extreme. They are closing down large institutions but not providing the resources for after care. There are clients who need long-term supervision to ensure that they are taking their medication and to ensure that they are safe - Mr Clunis was one and I want a public inquiry into why he was not given the provision of after care that he should have received (Guardian, June 29, 1993).

Martin Taube, Clunis’s solicitor, also joined the criticism against the government’s policy, and called for a full inquiry by people outside the medical profession (The Times, June 29, 1993). A spokesman for SANE, the schizophrenia charity, has argued that the Clunis case was not an isolated one (Daily Mail, June 29, 1993).

Among all the speakers that day Jayne Zito’s unique situation and message seem to have facilitated her particular influence on the ensuing public debate. She appeared to feel no hostility towards Mr Clunis, who was ‘not able to take responsibility’, and directed
her criticism at the Government (Hallam 2002: 30). Her tragic predicament gave enhanced credence to her otherwise more contested claim (House of Commons, Hansard Debates, 24 February 1994). 5 Moreover, Mrs Zito’s further activities helped maintain continuing publicity for the Clunis case. She initially campaigned alone for a public inquiry into her husband’s death, and was outspoken in her criticism of policy and politicians. After meeting with Virginia Bottomley and Health Minister John Bowis, she was reported to have said they were ‘patronizing’, and rejected their attempt to present the incident as a personal tragedy, rather than the result of the ‘care in the community’ policy. Her activity developed further during 1994, when she set up the Zito Trust, through which further statements on policy were made (Hallam 2002: 30). 6

The government’s initial response came from a spokesman for the Department of Health, who was reported to have said that the department was conducting a review of the legislation concerning care of the mentally ill, but it did not have responsibility for individual cases (Guardian, June 29, 1993).

On that same day, Prime Minister John Major was asked in the House of Commons by MP Dr. Jones will he:

(a)cept that although most people suffering from schizophrenia are not dangerous, the failure of the Government’s care in the community policy means that dangerous mentally ill people are walking the streets? What does he intend to do about that, and will he now order a public inquiry into the case and its implications for community care, as requested by Mr. Zito’s widow?“.

Major’s response was a mixture of responsibility dispersion and denial7:

… the care in the community policy has been a cross-party policy in the House for many years. … Nevertheless, I am sure that our community care policy is right for the patients concerned. It is right to encourage them generally to lead as independent a life as possible away from large-scale institutions. To that end, we now devote spending of more than £2 billion per year, and we have increased it substantially to ensure that the resources devoted to it are able to meet the problems which exist (Prime Minister questions, House of Commons, Hansard Debates, 29 June 1993).

However, only three days after the courts’ decision in the Clunis case, another killing by a released mental health patient was reported in the press. Michael Buchanan, who had a history of mental illness dating from 1983 pleaded guilty at the same court to the
manslaughter of Frederick Graver. Alison Graver, his daughter, was reported to have said following the court’s decision:

Innocent people are dying for no reason. The Government has got to review this ridiculous policy of putting mentally unstable people on the streets. My father died needlessly” (Independent, July 2, 1993).

Marjorie Wallace, chief executive of SANE, who was a central campaigner in the Stilcock case (see above) called for an immediate halt to the mental hospital closure program which led to the loss of 35,000 psychiatric beds between 1981 and 1991:

There is far too much pressure on psychiatrists to discharge people into the community before they are stabilised (Independent, July 2, 1993, see also Daily mail, July 2, 1993).

Following this recent case, The Independent reported that Virginia Bottomley, the Secretary of State for Health, accepted that better safeguards were needed for mentally ill people who had been discharged into the community, and that she is awaiting the conclusions of an internal review into the supervision of such people. Yet it was further reported that the Government was thought to favour tighter guardianship orders and increased community supervision rather than compulsory treatment of mentally ill people in the community who refuse to take prescribed treatment. It was said that stopping the closure of mental hospitals was not on the agenda (Independent, July 2, 1993).

On the evening of the next day (July 2), in an appearance on BBC television the Health Secretary Virginia Bottomley promised urgent action to improve the care of mentally ill people who are discharged from hospital, but ruled out radical changes to the community care policy. She said improvements were needed to protect the public as well as the patients. Mrs Bottomley said:

We need someone who is responsible for chasing up patients when they fall through the net. That particular person must say I’m the one to find out what has gone wrong (Times, July 3, 1993).

She was also reported to have said on BBC radio that

My worry is those most at risk – are we sure we have the mechanisms in place to supervise them, and I think the answer is no. We need further powers to make sure we do keep in touch (Guardian, July 3, 1993).
David Blunkett, the shadow health secretary, was quoted on the *Times* the next day calling for a complete review of community care policy:

> We can have little faith in Virginia Bottomley’s grasp of the reality of what government community care policy means. … There must be a suspension of any plans to close psychiatric units and a review of the way the present community care arrangements are operating to ensure that the resources are adequate for the system to work (*Times*, July 3, 1993).

On July 19, 1993 the *Independent* came out with a series of articles about the Clunis case, one of which, a 3,203 word report on the newspaper’s investigation of the events that led to the killing. It detailed a series of failures by hospitals, police, social workers and hostels over a period of seven years. The title of the leading article in that edition was “A suitable case for an inquiry”, and made the argument that given the failures found, a full public inquiry is required. But apart from the specific failings of the Clunis case, it had also pointed a finger at the ongoing policy of “closing asylums and caring for mentally ill people in the community rather than hospitals”, yet without providing or implementing adequate measures for a well-run community care system, such as proper support and supervision of patients treated in the community. The criticism of the Department of Health’s policy is summed-up by the observation that:

> It seems as if only half the community care policy has been properly put into practice, that of closing long-stay psychiatric hospitals (*Independent*, July 19, 1993).

Given the wide-ranging failures alleged by the *Independent*, the article concludes that only a fully independent and public inquiry is fitted to the task of drawing the required lessons.

On the following day the *Independent* reported about the joining of opposition members of parliament and charities in the call for a public inquiry into the Clunis case, that will also “examine the Government’s policy of emptying the asylums and treating seriously ill psychiatric patients in the community without adequate resources” (*Independent* July 20, 1993). David Blunkett, Labour’s health spokesman, was reported to have said:

> It is not good enough for Virginia Bottomley Secretary of State for Health to hold the inquiry in secret. The facts detailed in this case are both tragic and extremely worrying. The whole matter should be made open to public scrutiny so that the apparent catalogue of mistakes is not repeated (*Independent*, July 20, 1993).
On the next day it was reported that the Prince of Wales expressed concern over the Government’s care in the community policy (Independent, July 21, 1993), and details of the appointed inquiry were announced by the Department of Health. The inquiry was ordered by the Department of Health, and was to be organised by the North-east and South-east Thames regional health authorities (Independent, July 22, 1993), it was further announced that the independent inquiry will be chaired by Jean Ritchie (QC), a specialist in medical law and medical negligence, and be joined by Dr Donald Dick, a retired NHS consultant psychiatrist, and Richard Lingham, director of social services for the Scilly Isles (Evening Standard, July 21, 1993, Daily Mail, July 22, 1993).

The inquiry’s terms of reference were immediately criticised by the solicitor representing Jayne Zito, for limiting its scope to the period from May 1992 until the killing in December that year. He argued that given the fact that Clunis was diagnosed six years before as a schizophrenic, “the failure of the Community Care programme has to be considered against that history” (Independent and Guardian, July 22, 1993).

The inquiry team began to hear evidence on 20 September 1993 and concluded their hearings on 11 February 1994 – a period of nearly five months. Set up as a ‘private inquiry’, all hearings were held in private, but the findings and recommendations were publicised (Ritchie et al. 1994: 3-4).

The inquiry report

The inquiry report was submitted in February 1994. Notwithstanding the limited temporal scope of the inquiry’s terms of reference (the six months before the killing), which were criticised by Jayne Zito’s solicitor, the inquiry team obtained the consent of the two regional health authorities for extending their inquiries back to 1986 (Ritchie et al. 1994: 1). The report traced a “catalogue of failure and missed opportunity”, yet deliberately did not single out “just one person, service or agency for particular blame”. It concluded that the problem was a cumulative result of numerous failures and omissions by various people and agencies, which resulted in Clunis not receiving the good and effective care that he should have received (Ritchie et al. et al. 1994: 105).

A central comment was regarding inadequate transfer of information between various practitioners and institutions. The result was that each episode of illness in Clunis’ medical history was treated separately, rather than as part of a continuing illness, on each of his six admissions and attendances (Ritchie et al. 1994: 13). Moreover, the report found fault in the risk assessment of doctors, psychiatric nurses, and social workers, for failing
to adequately consider Clunis’s history of violence (Court 1994), and concluded that the decision to discharge Clunis from hospital care was wrong. The inquiry suggests that “the pressure to discharge patients from a Dickensian ward may have taken precedence over the health and well being of Christopher Clunis”. Furthermore no plan was made for his future care nor was the necessary information communicated to other mental health practitioners and institutions that might have been expected to care for him (Ritchie et al. 1994: 16).

The inquiry also criticized the police for not responding promptly to previous violent acts by Clunis, in particularly the fact that just eight days before the attack on Zito, Clunis was found wandering around the streets with a screwdriver and a breadknife, attacking people. The inquiry team concluded that the police were “not properly protecting the public from potential harm” (Ritchie et al. 1994: 107).

Apart from operational failures, the inquiry noted a shortage of some important resources. These included beds in Regional Medium Secure Units and general psychiatric wards for the population in the London Inner City area; a range of health service accommodation for those patients who require rehabilitation or cannot cope in the community on their own; a range of accommodation, providing varying degrees of care and supervision for patients cared for in the community; and sufficient numbers of Doctors and social workers for these tasks (Ritchie et al. 1994: 106). However, while determining that a lack of resources played a part in Christopher Clunis’s case, the report concluded that the government’s policy of ‘care in the community’ is “beneficial to the vast majority of people who suffer from mental illness” (Court 1994).

The report made twelve recommendations. They included setting up a special supervision group to cover the most difficult and disturbed patients nationwide.11 These patients would be cared for by specialist teams, their names would be placed on a national register, and new funds would have to be provided for their care. The team estimated that 3000-4000 patients would be on the list (Court 1994). Another recommendation concerned “investment in acute beds and ‘haven-type’ accommodation, specialist teams to work with people dimmed a potential risk to themselves or others, and training in mental illness for the police” (Hallam 2002: 30).

As noted, the report specifically avoided singling out a person, service or agency for particular blame, concluding that the problem was ‘cumulative’. However, despite this conclusion, in 81% of the press coverage of the Ritchie report blame featured prominently.
Seven articles singled out social services departments for blame and seven quoted the inquiry as blaming community care policy. The specific failings of the police and health services were each noted six times, and lack of resources received six mentions (Hallam 2002: 30-1).

A similar ‘reading’ of the report was evident from the reactions of some of the public figures of this affair. Following its publication Jayne Zito held Virginia Bottomley personally accountable for her husband’s death (Guardian, 25 February 1994), and Marjorie Wallace commented that the report acknowledged that ‘care in the community was failing’ (Times, 25 February 1994). However, one article warned against overreacting to the Clunis incident (Guardian, 25 February 1994).

The Government response to the report: risk assessments and mandatory inquiries

Pressure on the government to respond to the Richie report came from both the media and parliament (House of Commons, Hansard Debates, 24 February 1994). The Health Secretary responded to the report by announcing an extra £10 million for community based mental health services in London from 1995. She, however, did not announce any plans to create special supervision teams, as recommended in the report, despite the warning of the inquiry team that “only if the whole package is provided will care in the community work effectively” (Court 1994).

On 10 May 1994, one month after the publication of the Ritchie report, the Department of Health has issued guidelines on the discharge of mentally disordered people and their continuing care in the community (NHS Executive 1994). The guidelines concentrated on issues of risk assessment, mindful consideration of ‘essential elements of an effective care programme’ such as keeping close contact with the patient, adequate monitoring of the care programme, taking of immediate action when the programme is not delivered properly, and the proper transfer of information among health service providers.

The advent of mandatory inquiries into homicide by mental patients (1994-2001)

It appears that for the Department of Health the Ritchie inquiry became a model for inquiries after homicide by mentally ill people (Rumgay and Munro 2001: 358). Section 34 of the NHS Executive (1994) introduced a general requirement to hold an independent
inquiry in cases of homicide by mental patients (while leaving it optional in other violent incidents). Section 36 specifies some procedural aspects of such mandatory inquiries. The remit (terms of reference) of the inquiry should at least encompass the care the patient was receiving at the time of the incident; its suitability in view of the patient’s history and assessed health and social care needs; its correspondence with statutory obligations, Department of Health guidance, local operational policies, professional judgment; and the adequacy of the care plan and its monitoring. The composition of the mandatory inquiries’ panel also mirrored that of the Ritchie inquiry, requiring a lawyer as chairperson, joined by a psychiatrist and a senior social services manager and/or a senior nurse. Members of the panel were not to be employed by bodies responsible for the care of the patient. This in fact allows panel members to be employed by other bodies of the healthcare system, in other words, not independent from the Department of Health, or from the government as a whole. Finally, section 36 noted that “it will not always be desirable for the final report to be made public, and undertaking should be given at the start of the inquiry that its main findings will be made available to interested parties”.

Indeed this requirement led to a sharp increase in the number of inquiries into such incidents, from only two NHS inquiries in the 1970s, five in the 1980s, and 52 between 1990 and 2002 (Walshe & Higgins 2002: 895). Yet while mandating inquiries in cases of homicide by mental patients, section 36 somewhat relaxes the ‘independence’ criterion on these tribunals, and the publicity of their reports, by proposing a default choice of confidential reports.

The Ritchie report concentrated on risk evaluation and risk management of mental health practitioners, and apart from a comment on the lack of resources, did not find the policy to be faulty. This rather selective emphasis downplayed the role of scarce resources to provide adequate and suitable mental health, although the inquiry found that Clunis was taken to hospital by probation staff daily for eight days, but on each occasion the intention to admit him was thwarted by lack of a bed (Rumgay and Munro 2001: 361).

Consequent inquiry reports into homicide by mentally ill people under section 36 had placed a similar emphasis on failures of risk identification and management. This apparently unbalanced attention to more systemic aspects of such failures is further exacerbated by Rumgay and Munro (2001) claim, based on the analysis of forty such inquiry reports, that inadequate hospital provision can be expected to lead practitioners
to downplay risks and ignore otherwise worrying indications. Inquiries’ tendency to concentrate on the failures of individuals, especially in the field of risk assessment came under attack in recent years. It appears that inadequate care, and response to patients that start to relapse, is a more frequent antecedent of homicide by mental health patients than (retrospectively evaluated) flawed risk assessment (Munro and Rumgay 2000), and concentration on personal culpability presents a challenge for more systemic lesson drawing (Munro 2004).

### Limited scope of lesson drawing and flawed conclusions

It is suggested here that the concentration on operational aspects, while ignoring wider issues of resources and policy have paradoxically led to what appears to be an unfounded conclusion about the merit of the policy. This is rooted in false impressions regarding the scale of the policy problem, which are interconnected with an unfounded assessment of the effectiveness of the policy.

**Biased perception of the policy problem:** Following the Ritchie and Boyd reports, as well as the House of Commons Health Committee (2000) a general consensus has developed, shared also by the government, that community care has failed (Hallam 2002: 31). A series of inquiry reports indicated similar and repeating operational flaws in community care associated with homicides by mental patients. Yet the Boyd inquiry report (1996) provides a useful analysis, making the point that deaths by homicide and suicide among those with a psychiatric history represent only a small percentage of deaths by homicide and suicide more generally (Boyd 1996: 81, Manthorpe 2002: 2). Boyd points to the fact that many cases of violence in the community are reported several times (the event, the court case, and the inquiry report), thus greatly exaggerating the impression about the number of cases.

While the trigger for public and policy attention to mental health policy were violent incidents involving mental health patients, there was little fluctuation in the number of people with a mental illness committing criminal homicide between 1957 and 1995. In fact, given that the total number of homicides increased by 450% in this period, there was a 3% annual decline in the contribution of mental patients to the official statistics (Taylor and Gunn 1999). Taylor and Gunn (1999) conclude that:

> There are many reasons for improving the resources and quality of care for people with a mental disorder. But there is no evidence that it is anything but stigmatising to claim that their living in the community is a dangerous experiment that should be reversed.
**Questionable assessment of the effectiveness of the policy:** The relatively narrow scope of inquiries on operational aspects of individual cases restricted them from relatively evaluating the merit of alternative healthcare programs. Hallam (2002: 32) notes that the public are less familiar with other (equally tragic) victims of the mental health care system, namely those who died in mental hospitals, or as a result of neuroleptic drugs. Such deaths were estimated at about one a week at the time of the Clunis and Silcock incidents, but there was very little public outcry about deficiencies in the care provided in these cases (Hallam 2002: 32).

Moreover, it has been argued that the most notable change in hospital use has been the reduction in long-term care beds, while a full range of community care services were not developed. Thus given this partial implementation of the policy, judgment of its success or failure is not warranted (Hallam 2002: 31).

Finally, the requirement to set up independent inquiries in cases of homicide by mental health patients was withdrawn in 2001, when the Department of Health introduced a new way of investigating such cases – now classified as ‘adverse events’ – by mandatory reports to a new NHS-wide reporting system run by a newly created National Patient Safety Agency (NPSA) (Munro 2004: 476).

**Setting the Stage for Analysis**

The Clunis case presents an interesting case for demonstrating the detrimental effect of the politics of inquiries to policy learning. The Ritchie inquiry was appointed following great public concern and media involvement. Although the Clunis case itself did not receive great public attention at first, it was preceded and followed by similar events, probably most notably the Silcock incident. These events concentrated over a short period, and created a sense of a general problem of policy, which rendered denial of a problem – explicitly or implicitly – politically unfeasible. One should also note the apparent unique contributions of two articulate and energetic women to the central place the Ben Silcock and Clunis cases came to take on the public agenda – Marjorie Wallace, and Jayne Zito, respectively.

Yet, the perceived policy problem as apparent increase the incidence of homicides by mental health patients, coupled with a policy change in the field of mental care appears to be unfounded. The rate of homicides by mental patients did not increase over the relevant period of the policy change. Furthermore, the implementation of the policy known as ‘care in the community’ was not complete. The Ministry of Health, on its
part, limited the scope of the inquiry to mostly operational aspects of the particular case, with only limited reach into policy. The resulting report was a thorough assessment of operational aspects of the Clunis case, but with limited possibility for inferring from it to the broader challenge of mental health care.

Politically, one may argue that the Ritchie inquiry was optimal. It addressed the pressure for inquiry, yet limited itself to operational aspects. That can account for it becoming a model for future inquiries, and the introduction of mandatory inquiries of the same type in 1994. The apparent inefficiency of these inquiries for policy learning is apparent from their repeating findings over the years (see: Walshe and Higgins 2002: 899 regarding NHS inquiries, and Elliot and McGuinness 2002 regarding rail disasters).

Thus, the combination of a public pressure to appoint – drawing on biased perception of the policy problem – coupled with a political endeavor to restrict the scope of the inquiry to operational case-specific aspects rather than systemic policy ones, have produced a thorough yet limited process of accountability, and a poor policy learning process.

This begs a number of questions about the role of inquiries. Should we settle for inquiries that provide an account on the operational failings in particular cases only, or do we expect them also to play a major role in facilitating policy learning? A tentative answer can be that inquiries appointed after crisis can be expected to suffer more from these limitations compared with inquiries appointed by the government out of its own initiative, and not as a response to a crisis. In that respect the change from mandatory inquiries into homicides by mental patients to ongoing reporting system of ‘adverse events’ appears to be a positive change.
Endnotes

1 Sulitzeanu-Kenan (2006a) definition is intended to define ‘public inquiries’, and concentrated on discretionary ones, so it included two more criteria: (a) inquiries establishes “as a result of the appointer’s discretion”; and (b) that the inquiry is conducted in a public way (Wade and Forsyth 1994: 1007), which allows exposure of relevant facts to public scrutiny (Clarke 2000: 8).

2 Gove referred to ‘judicial inquiries’ but the same applies to the wider category of post crisis inquiries.

3 Hallam (2002) found seventy-six articles about the Ben Silcock incident in the national press in January 1993. This figure represents high media salience, and one that was never exceeded by the Clunis affair, even after the end of his trial in June 1993.

4 The first account of the Clunis trial was a day earlier (28.6.1993) in the Evening Standard, but mentioned only that Clunis had failed to keep outpatient appointments. No indication was made to his diminished responsibility, and that his sentence was to be held in a secure hospital indefinitely (Hallam 2002: 30).

5 One title of an article in the Independent (July 19, 1993) reflects this point: “The Clunis Case: A dignified widow who bears no hatred”.

6 The Zito Trust is still active today as a registered mental health charity: www.zitotrust.co.uk

7 For more comprehensive reviews of accounts types see: McGraw (1991) and Hareli (2005).

8 The Ritchie report mentions this article as one of two documents that assisted the early stages of the inquiry (Ritchie 1994: 1).

9 It was submitted to the Chairman of North East Thames and South East Thames Regional Health Authorities (Ritchie et al. 1994), who set up the inquiry at the instruction of the Secretary of Health (Independent, July 22, 1993).

10 It is possible that had the inquiry not extended its remit, this systemic flaw would not have been detected.

11 Patients in this group would satisfy two of the following criteria: they have been detained more than once, have a history of violence or persistent offending, have failed to respond to treatment from the general psychiatric services, or are homeless.

12 Moreover, although Munro and Rumgay (2000) suggest that the role of flawed risk assessment is relatively smaller than adequate care, their findings should be regarded as an overestimation of the role of flawed risk assessment, since they relay on the judgment of inquiries that obviously looked only on cases that ended up in the risk being materialized (homicide). This ignores unavoidable hindsight bias (Fischhoff and Beyth 1975) on the part of these inquiries, and suggests that the actual proportion of flawed risk assessments is even lower than determined by inquiries.
Discussion Questions

1. Did the Ritchie inquiry provide an effective accountability measure?

2. What were the advantages and shortcomings of the inquiry’s report?

3. In what ways did the characteristics of the political aspects of independent inquiries (presented in the first section) come to shape the process and outcome of the Ritchie inquiry?

4. Given what you have read on the Ritchie inquiry, what, if at all, should be the role of independent inquiries after such incidents?

5. From the analysis of the Ritchie inquiry, how does ‘problem definition’ relates to accountability?
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